Waterloo Wellington **LHIN**

Better Health, Better Futures: A Foundation for Moving Forward

2011-2012 Annual Report

Ontario

Local Health Integration Network

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Message from our Chair and CEO

On behalf of the Board of Directors, we are pleased to provide you with a copy of our 2011 – 2012 Annual Report.

Joan Fisk, Board Chair

Over the past year, the WWLHIN has continued to develop and build a strong foundation of collaboration within our community to improve the lives of our 750,000 plus residents. We have concentrated on the most effective use of taxpayer dollars through a focus on accountability and quality. We have achieved lower wait times, greater access to care, and sustainable quality improvements in the delivery of health care. We would like to acknowledge the team here at the WWLHN whose hard work, dedication, and enthusiasm has resulted in many achievements in transforming our local health system.

Each year, the WWLHIN spends over $970M to provide health care services to our residents, ranging from emergency department care to homecare, from surgeries to primary care, from meals on wheels to long-term care, from mental health and addictions programs to day programs for seniors. We rely on our thousands of talented nurses, doctors, allied health professionals, technicians, support staff, volunteers and administrators to carry out this work on our behalf. And we are grateful for the skill, dedication, and compassion they bring to the job each and every day.

Bruce Lauckner, CEO

While this Annual Report shares the progress of where we have come, we are most excited about where we are going. In 2011 – 2012, we welcomed a number of new members to our Board of Directors. In addition, the Government launched its Action Plan for Health Care, which includes additional responsibilities for LHINs. The Board took this opportunity to re-examine the WWLHIN's mission, vision, values and strategic priorities. Through the latter part of the year, we developed a bold new strategy for our local health system.

As the leaders of the local health system in Waterloo Region, Wellington County, Guelph and southern Grey County, our mission is to lead a high-quality, integrated health system for our residents. Integrated health systems help patients move through the system as seamlessly as possible without having to figure out who to call or how to book that next specialist appointment. Integrated systems ensure someone is there when we come home from hospital. And integrated systems ensure information follows us so we don't have to keep repeating our symptoms to the next practitioner, explaining what medications we're on, or undergoing duplicate tests. Integrated health systems lead to better health outcomes, better patient/client experiences and better value for taxpayer dollars.

Going forward, we are guided by our core value which is acting in the best interests of our residents' health and well being. As we move forward, we are counting on our health service providers and partners to step-up and drive the change needed. This means looking beyond the four walls of an organization and seeing the health and care needs of the resident as first priority. As the leader of the Waterloo Wellington health system, it is our mission to ensure this happens and we are prepared and ready for this exciting opportunity.

We will act in the best interests of our residents ahead of the self-interests and silo thinking that has too often dominated our system in the past. Many new leaders are emerging in our health system; leaders who are also willing to put the interests of our residents first and focus on the Triple Aims of Better Health, Better Care and Better Value. Moving forward we will support these leaders ahead of others as we need to accelerate the pace of integration.

This Annual Report summarizes the goals we set for the system over the past year, and summarizes the achievements we have made in partnership with our health service providers. Building on this success, we look forward to continued collaboration to provide better health and better futures for our residents.

Joan S. Fisk

Bruce Lauckner

Members of the Board, 2011-12

Joan Fisk, Chair
June 2, 2011 – June 1, 2014

Dale Small, Vice-Chair
Nov. 18, 2009 – Nov. 17, 2012

Manjit Basi
Oct. 6, 2010 – Oct. 5, 2013

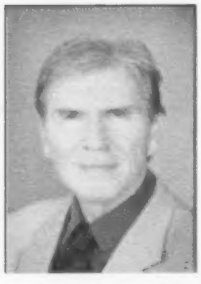
Bonnie Bremner
Apr 18, 2011 – Apr 17, 2014

Lynda Davenport
Oct. 27, 2010 – Oct. 26, 2013

Bill Dinwoody
Dec 2, 2009 – Dec 1, 2012

Judy Dirksen
June 2, 2011 – June 1, 2014

Paul McDonald
May 17, 2011 – May 16, 2014



Murray O'Brien
June 2, 2011 – June 1, 2014

WWLHIN Governance Structure

The WWLHIN is governed by a board of nine directors who are selected by the Lieutenant Governor in Council and appointed through Order in Council. Members hold office for a term of up to three years and may be re-appointed for one additional term. The Lieutenant Governor in Council is responsible for designating the Chair and Vice-Chair from among the members. The board is skills-based, drawing on local individuals with a variety of experiences and expertise.

Waterloo Wellington Local Health Integration Network board meetings are open to the public. There are three standing committees of the board – Finance and Audit, Governance and Nominations.

Introduction to the Waterloo Wellington Local Health Integration Network (WWLHIN)

The Waterloo Wellington Local Health Integration Network (WWLHIN) is one of 14 LHINs established across Ontario in recognition that health care services are best managed at the local level where they can be delivered through an integrated approach and with input from the community. The WWLHIN is responsible for planning, integrating and funding health services in Waterloo Region, Wellington County and south Grey County.

LHINs are the only organizations in Ontario that bring together health care partners from the following sectors - hospitals, community care, community support services, community mental health and addictions, community health centres and long-term care - to develop innovative, collaborative solutions leading to more timely access to high quality services for the residents of Waterloo Wellington and Ontario. By supporting these important partnerships, LHINs are ensuring that Ontarians have access to an effective and efficient health system that delivers improved health results and a better patient experience.

An integrated health system for Waterloo Wellington means:

> *A system that is easy to use and access, is coordinated and effective, promotes health and wellness, ensures the highest quality of care and services, recognizes and leverages the contributions of all stakeholders, encourages innovation, partnership and excellence and will be there for us today and tomorrow.*

WWLHIN Vision

Better Health – Better Futures

WWLHIN Mission

To lead a high-quality, integrated health system for our residents.

WWLHIN Core Value

We value acting in the best interest of our residents' health and well-being.

Health Services in the Waterloo Wellington LHIN

The Waterloo Wellington LHIN is responsible for planning, integrating, coordinating and funding 77 health service providers:
1 Community Care Access Centre
4 Community Health Centres (with 4 satellites)
12 Community Mental Health and Addictions Agencies
18 Community Support Service Agencies
8 Hospital Corporations (10 hospital sites)
34 Long Term Care Homes
A complete list of funded health service providers can be found on the WWLHIN website, www.wwlhin.on.ca.

Our Community

As of 2012, the WWLHIN is home to approximately 745,000 residents, representing 5.6% of Ontario's total population. Between 2009 and 2022, the WWLHIN will experience a population growth of 16.2%, and is projected to be the sixth fastest growing LHIN in the province. The expected provincial population increase during the same time period is 15.6%. The population growth of WWLHIN residents 65+ years between 2009 and 2024 is projected to be faster than that of the provincial growth (68.6% vs. 62.8%). However, the percentage of Waterloo Wellington residents who are 65+ years is currently lower (12%) than that of Ontario average (13.5%) and is projected to remain lower through 2024.

Our Health

Health is depicted in a variety of ways. Here is a snapshot of some of some common factors affecting health.

Residents in the WWLHIN area are increasingly engaging in unhealthy behaviors. Data from the 2011 Statistics Canada Health Profile, informs us that there are a high percentage of obese or overweight people in Waterloo Wellington, 52.8% compared to the provincial average of 52%. During the time period of 2003 - 2009, the obesity average increased by 20.1% in WWLHIN compared to the provincial change of 8.7%.

Participation in physical activity has increased, though only slightly from 2003 - 2009 in both the WWLHIN (0.8 per cent) and the province (2.8%). The percentage of heavy drinkers in the WWLHIN in 2011(17.9%) is higher than the provincial average (15.9%). While daily smoking in 2009 is at 17.8% in Waterloo Wellington, this represents an 18.4% decrease since 2003.

In 2011, 92.1% of local residents had contact with a medical doctor in the past 12 months, a 12% increase since 2009 and 1% higher than the provincial average. The percentage of local residents with: diabetes was 6.9% which is slightly higher than the provincial average. In addition, per 100,000 residents, 368 were hospitalized for an injury, 118 were hospitalized for stroke, and 206 were hospitalized for a heart attack. Since 2009, all of these rates of hospitalization have decreased and rates of hospitalization for injuries and stroke are now below the provincial average.

While 87.6% of residents completed high school, only 59.8% have completed post-secondary education. The unemployment rate in 2011 was 7.7%, with 9.8% of the population considered to be low-income. Since education, literacy rates and income are determinants of health, improvements in these areas will impact health outcomes for our residents.

Waterloo Wellington LHIN Geography

The WWLHIN covers approximately 4,800 square kilometers of land. Almost 90 per cent of the WWLHIN's total geographic space is rural.

Accountability

Ministry-LHIN Performance Agreement

The WWLHIN and the Ministry of Health and Long-Term Care (MOHLTC) have negotiated and signed a performance agreement which defines the obligations and responsibilities both the LHIN and the Ministry have to each other over a defined period of time. The Ministry/LHIN Performance Agreement (MLPA) includes a number of schedules which outline expectations of the LHIN regarding Community Engagement; Planning and Integration; Local Health System Management; Financial Management; Local Health System Performance and Reporting.

Health System Performance

Over the past year, the WWLHIN has worked closely with health service providers on initiatives to improve access to care and quality of care for local residents. The WWLHIN remains a top performer in a number of key priority areas including access to Cancer Surgeries and Cardiac By-Pass procedures.

Wait times for cataract surgery and hip and knee surgery increased over the past year due to a number of influencing factors including increased demand for these procedures. The wait time for CT Scans increased due to incorrect data capturing at one of the sites and staffing concerns at another. The WWLHIN continues to engage its health service providers and the Waterloo Wellington Wait Time Steering Committee to evaluate these factors and implement strategies to reduce wait times.

While MRI wait time gains were held over the past year, the addition of a new MRI at Cambridge Memorial Hospital operating for 2012 – 2013 will help bring the wait time closer to the provincial target of 28 days.

Hospitals across the WWLHIN experienced increasing numbers of patients visiting their emergency departments (ED). Despite the increase in visits to the emergency department, the number of days patients who no longer required acute care but remained in hospital waiting for community care decreased. This can be attributed to the many new Aging at Home initiatives the LHIN funded to provide care for people in their homes,, more long-term care beds, the implementation of the Home First philosophy, and increased collaboration between hospitals, long-term care, CCAC, and community support services to improve patient flow throughout the system.

Remarkable progress has been seen in reducing the number of patients waiting in hospital for long-term care. The Waterloo Wellington LHIN currently has the lowest percentage in the province of of people waiting in hospital for a long-term care bed. The WWLHIN will continue to work with its partners to reduce the number of days people wait in hospital when they are ready to go home.

Over the last year, the Waterloo Wellington LHIN and its health service providers also reduced emergency department lengths of stay for patients being admitted to another hospital program by almost 11 per cent over the past year, ranking the WWLHIN #1 in the province.

Overall, we are proud of the work accomplished this past year in partnership with the many talented nurses, doctors, allied health professionals, technicians, support staff, volunteers and administrators in our 77 health service providers. There is more to do and we are committed to achieving even better results in the year to come.

MLPA Performance Indicators

The Ministry-LHIN Performance Agreement sets out the mutual understandings between the Ministry of Health and Long-Term Care and the WWLHIN of their respective performance obligations in the period covering the 2011-2012 fiscal year. The following table outlines WWLHIN performance against targets for 2011/12. We are proud that we have set some of the most aggressive targets of all the LHINs and also show our rank provincially.

Performance Indicator	LHIN 11/12 Starting Point	LHIN 11/12 Performance Target	Most Recent Quarter 2011/12 LHIN Performance	Percent from Target for Most Recent Quarter Result*	FY 2011/12 LHIN Annual Result	Provincial Rank out of 14 LHINs
Emergency Room/ALC						
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution***	16.88%	**9.46%**	18.35%	92.9%	**17%**	10
Hospitals discharged several long-term ALC cases and these are reflected in the results for Q3 11/12. Recent trend of ALC patients (over the past 9 months) shows consistently fewer patients in ALC. The system has applied resources to expanding community capacity and implementing Home First, which has reduced the number of ALC days accumulated waiting for LTC by almost 40%.						
90th Percentile ER Length of Stay (LOS) for Admitted Pts	29.32	**20.00**	24.05	20.3%	**26.12**	5
In the most current quarter of the new fiscal year, Q1 2012/2013, the WWLHIN has reduced the ED LOS for admitted patients by nearly 11% over the previous fiscal year and now ranks #1 in the province.						
90th Percentile ER Length of Stay (LOS) for Non-Admitted Complex (CTAS I-III) Patients	7.52	**6.80**	7.97	17.2%	**7.62**	10
ED LOS for non-admitted complex patients has remained relatively the same over last year with Q4 having a higher LOS than the rest of the year. Two sites, Guelph General and Groves Memorial, continue to perform under target; however, the organization's which see the most patients have greater impact on the 90th Percentile ED LOS.						
90th Percentile ER Length of Stay (LOS) for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	5.12	**4.10**	5.00	22%	**4.87**	11
While the ED LOS remains over-target, the WWLHIN has reduced the ED LOS for non-admitted uncomplicated patients nearly 5% over the previous fiscal year. As with the performance for the non-admitted, complex patients, Guelph General and Groves Memorial continue to perform under target; however, higher volume organizations have a longer 90th Percentile ED LOS.						
Surgical Wait Times						
90th Percentile Wait Times for Cancer Surgery	49	**49**	53	8.2%	**48**	**5**
The wait time for cancer surgery in WWLHIN remains better than target.						
90th Percentile Wait Times for Cardiac By-Pass Procedures	34	**34**	26	-23.5%	**25**	1
The wait time for cardiac surgery in WWLHIN remains better than target.						
90th Percentile Wait Times for Cataract Surgery	92	**76**	90	15.6%	**103**	3
The wait time for cataract surgery has risen with variable wait times for some surgeons.						
90th Percentile Wait Times for Hip Replacement	120	**103**	124	20.4%	**142**	3
The wait time for hip replacement surgery has risen with variable wait times for some surgeons.						
90th Percentile Wait Times for Knee Replacement	169	**115**	202	75.7%	**218**	**9**

The wait time for knee replacement surgery has risen with variable wait times for some surgeons.						
Diagnostic Wait Times						
90th Percentile Wait Times for Diagnostic MRI Scan	62	**28**	72	157.1%	**67**	2
Both sites are operating at near maximum capability and pressure from the ED has impacted performance. Another MRI machine is online for FY 12/13.						
90th Percentile Wait Times for Diagnostic CT Scan	33	**28**	27	-3.6%	**31**	9
The wait time for diagnostic CT Scan remains better than the target.						
Excellent Care for All/Quality						
Readmission within 30 days for selected CMGs**	14.81%	**14.00%**	14.82%	5.9%	**14.02%**	**2**
Performance during 3 of the past 4 quarters has been below target, with Q1 11/12 showing a readmission rate around 16%. Reductions in the readmissions for the Cardiovascular and Gastrointestinal cohorts has lead to the lower rate of readmission in Q2 11/12.						
Mental Health and Substance Abuse						
Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions**	14.80%	**13.20%**	16.72%	26.7%	**15.6%**	5
Q2 11/12 performance is on par with Q3 & Q4 10/11 and is higher than the previous quarter. In Q2 11/12, repeat visits for mood disorders and stress-related and neurotic disorders increased. These two diagnostic groups represent the majority of the repeat visits and the overall impact is greater than other diagnostic groups.						
Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions**	21.8%	**18.75%**	18.91%	0.9%	**19.07%**	4
Better performance in this past quarter is attributable to lower repeat visits for alcohol use.						
Access to Community Care						
90th Percentile Wait Time for CCAC In-home Services – Application from Community Setting to first CCAC Service (excluding case management)	36	**34.20**	25.00	-26.9%	**25**	**5**
Performance on this indicator continues to be below the 4-week target.						

* A negative percentage means the LHIN has met its target. ** FY 2011/12 is based on only 3 quarters of data (Q1-Q3 2011/12) due to availability. ***FY 2011/12 is based on most recent four quarters of data (Q4 2010/11 – Q3 2011/12) due to availability.

Integrated Health Service Plan (IHSP)

Working Together for a Healthier Future, Integrated Health Service Plan, 2010 - 2013

In 2009 – 2010, in partnership with health service providers and local residents, the WWLHIN updated the community's Integrated Health Service Plan (IHSP) for Waterloo Wellington's health system. Since then, guided by that plan, the WWLHIN and local health service providers have made great strides in improving access to high quality health care services for local residents.

The strategic plan presents a detailed description of the local priorities, an implementation plan and how success will be measured. To address the eight priorities, the IHSP outlines the system improvement initiatives that will be implemented over the three-year period of the plan. The initiatives were developed with the individuals, networks and organizations that will be responsible for putting the plans in action. Review and measurement has been rigorous and ongoing to support success and assist in making any necessary adjustments to the plan along the way. These initiatives are supported through Aging at Home, and integration activities.

IHSP Priorities

The Waterloo Wellington Working Together for a Healthier Future, IHSP, 2010 - 2013 focuses on the following eight priorities:

- improving patient safety and enhancing quality of care
- improving access to emergency department (ED) care
- decreasing alternate level of care (ALC) days.
- improving access to primary care
- improving access to, and coordination of, addictions and mental health services
- improving chronic disease prevention and management (including diabetes)
- improving outcomes for stroke patients through integrated programs
- improving wait times for MRI exams

eHealth, health human resources, and strategic leadership are three vital enablers that will facilitate the achievement of system improvement and transformation.

Improving Patient Safety and Enhancing Quality of Care

The WWLHIN, through extensive community engagement and consultation, identified 'Improving Patient Safety and Quality of Care' as an overarching priority. This priority was echoed by the Ontario Health Quality Council (now Health Quality Ontario) who found that Ontarians share a common vision of a high-performing health system and who want a publicly funded health system that is accessible, effective, safe, patient-centred, equitable, efficient, appropriately resourced, integrated and focused on population health.

Goal: Our goal is to implement initiatives that will see 95 per cent of residents satisfied with the care they receive. We want to have the lowest adverse events and infection rates in the province, and we will work to eliminate duplication of administrative, support and clinical activities.

Successes:

- ✓ Overall, across the WWLHIN, Hospital Standardized Mortality Rates have been steadily decreasing over the past several years across all our hospitals.
- ✓ Readmission rates to hospital following acute care continue to fluctuate in the WWLHIN, but remain near or below the provincial benchmark. This success is the result of a number of initiatives such as: Nurse-led outreach teams, GEM Nurses in EDs, enhanced CCAC Services, Intensive Geriatric Service Workers, the implementation of the Easy Coordinated Access project, and more.
- ✓ In April 2011, all hospitals in WWLHIN developed their first Quality Improvement Plans (QIP), as required under the Excellent Care for All Act.

Improving Access to Primary Care

Primary health providers play an important role in prevention of disease and management and treatment of chronic conditions. Recognizing the role of primary care as fundamental to early identification and intervention for chronic disease, the WWLHIN is committed to ensuring that these services are easily accessible for all residents in Waterloo Wellington and that the primary care sector is integrated with all points on the health care continuum.

Goal: To ensure all residents of Waterloo Wellington have access to primary care, improve utilization of primary care by vulnerable populations and increase the number of residents who access after-hours care.

Successes:

- ✓ Approximately 95 per cent of residents in Waterloo Wellington have a primary care physician or place where they go for regular primary care which is slightly higher than the provincial average of 93 per cent.
- ✓ Opening of New Nurse Practitioner-led Clinic in Cambridge and the Shelldale site of the Guelph Community Health Centre.
- ✓ Appointment of new Primary Care Lead Dr. Sabrina Lim Reinders
- ✓ Health Care Connect, a provincial program that helps people who do not have a primary care provider to find one, has had from February 2009 – October 2011 9,450 Waterloo Wellington residents registered with the program. Of those, 4,681 were referred to a primary care provider.

Improving Outcomes for Stroke Patients through Integrated Programs

Transitioning to an Integrated System of Rehabilitative Care

In mid-2011, the WWLHIN launched a Rehabilitation Services Review to identify opportunities to streamline the rehabilitation system to increase access to care and provide better outcomes for patients. Extensive engagement was conducted with health care providers, professionals, and patients to identify challenges and opportunities for improvement.

The Report recommends the development of a "System of Rehabilitative Care" that is organized around four condition-specific "Streams of Care". To further align the WWLHIN's Stroke Care Review with the Rehab Review, the Stroke Care Review has now become part of the Rehabilitation Review as one of the four "Streams of Care". While the Stroke Care Stream is further along in development than the other streams, it is well aligned with the broader rehabilitation care model and is again grounded in evidence-based best practice.

Transitioning to an Integrated System of Stroke Care

Within the WWLHIN, stroke was the third most common cause of death and the ninth most common chronic disease. The risk of stroke is increased by a number of factors, including age, chronic conditions such as diabetes, and unhealthy lifestyles. It has been estimated that by 2024 the number of strokes in the WWLHIN may increase by as much as 50%.

Goal: to improve prevention and management of patients at risk of stroke by primary care providers and reduce readmission rates and mortality rates to the provincial average.

Successes:

- ✓ A model for an integrated stroke program in WWLHIN has been locally developed.
- ✓ It has been recommended that all stroke care in WWLHIN will be provided in a "banding model". The band a patient is placed in is determined by the results of their evidence-based assessment.
- ✓ Guelph General Hospital has co-located stroke patients at their facility and these patients are being treated by staff trained specifically in stroke care.

Increasing Your Chances of Surviving a Heart Attack

James was at home when he started feeling unwell. He had what felt like painful indigestion and nausea. He started sweating and began having pain in his left arm and then hand. That's when the retired-teacher knew he was in trouble. He called 911 to tell them he thought he was having a heart attack and then called his son to say that EMS was on their way.

St. Mary's General Hospital (SMGH) has developed a close partnership with Waterloo Region Emergency Medical Services to ensure patients in Waterloo Region receive the fastest access to emergency angioplasty to open arteries that are blocked during a heart attack. Ambulances in Waterloo Region are equipped with electrocardiogram (ECG) machines which paramedics use to see if a patient is having an ST elevation myocardial infarction (STEMI), a heart attack caused by a blockage in an artery.

"Our paramedics are specially trained to do an ECG within 10 minutes of arrival," said Roger Mayo, Manager, Waterloo Region EMS. "The results are immediately analyzed to determine if the patient is having a heart attack. We then call directly to the interventional cardiologist at St. Mary's to discuss the patient's situation. While we drive the patient to the hospital, the Cardio team prepares to receive the patient and immediately intervene."

When James called 911, EMS arrived at his door in 6.5 minutes, took his ECG, and was en route to the hospital in 12 minutes. After 22 minutes, he had bypassed the emergency department and arrived directly to the Catheterization lab on the 2nd floor at the hospital. A month later, James was well enough to share his story with others at St. Mary's Annual Community Heart Month Event.

Improving Wait Times for MRI Exams

Wait times are measured from the time the MRI exam is booked until the time the exam is completed. Over the past four years, we have seen a significant improvement in wait times for MRI exams – moving from one of the longest wait times in the province to the 2nd best. However, wait times are still too long.

Goal: Our goal is to decrease wait times from the wait time of 82 days to meet the provincial target of 28 days.

Successes:

- ✓ The WWLHIN has allocated 57% more volumes for MRI scans in 2011-12 when compared to 2009-10.
- ✓ The MRI/CT working group, through the support and leadership of the WWLHIN, is reviewing how facilities can deliver better quality care by focusing on completing surgeries within the prescribed time for each priority level.
- ✓ A new MRI was opened at Cambridge Memorial Hospital in 2012
- ✓ Reduced wait times from 163 days in 2008 to 67 days in 2012.

Improving Access to Emergency Department (ED) Care

As part of the WWLHIN's commitment to improving patient safety and enhancing quality of care, improving access to Emergency Department (ED) Care has been identified as a priority and a sentinel indicator of overall system quality. This prioritization is consistent with research that demonstrates patients who visit EDs at times when waits are longer are more likely to experience an adverse event, and suggested the best strategy to avoid this risk is to reduce the overall length of stay in EDs for all patients (Guttmann et al., 2011).

Six hospital corporations within the WWLHIN boundaries operate Emergency Departments at seven sites. Together, these hospitals provided service for 266,429 ED visits in 2010-2011. Understanding both the pressures of a growing community and the risks of overcrowded EDs, the WWLHIN, with health service providers, is dedicated to optimizing appropriate care for patients.

Goal: non-urgent ED visits (CTAS 4,5) will be reduced by 10 percentage points by ensuring appropriate utilization of ED resources.

Successes:

- ✓ To help achieve the targets, five WWLHIN hospitals have participated in different stages of two provincial programs: The Process Improvement Program (PIP) and the Pay for Results (P4R) Program.
- ✓ From the 2008-09 to 2011-12, the 90th Percentile Wait Time for admitted patients decreased from 29.2 hours to 27.9 hours.
- ✓ Expanded Geriatric Emergency Management (GEM) nurses in EDs which has resulted in improved follow up care for seniors at risk of functional decline.
- ✓ Implemented Intensive Geriatric Service Worker (IGSW) program to better connect seniors at risk to appropriate community support services.

COPD Clinic Improves Patients' Quality of Life

As a Nurse Practitioner, Loretta McCormick admits that some patients are puzzled when their doctor refers them to her at the Cambridge Memorial Hospital Chronic Obstructive Pulmonary Disease (COPD) Clinic for care.

"At first, they aren't quite sure what a Nurse Practitioner is or what I can do for them," said Loretta. "But once we meet and they better understand the clinic and the care I will provide for them, they always wish they had been referred sooner."

Loretta works closely with two Respirologists, Dr. Macie and Dr. Mathai, and family doctors to help patients better manage their COPD. COPD is one of the most common lung diseases. It is a progressive, chronic disease that makes it difficult to breathe.

The COPD clinic has three important goals – to reduce flare-ups of a patient's COPD through education and managing their medications, helping the patient to better understand their chronic illness, and reducing emergency department visits by providing specialized follow-up care for patients after a serious hospital visit.

"A chronic illness doesn't go away," she explained. "There are going to be times when it is well managed and there will be times where it flares up. We help patients to understand exactly what to do if it flares up. This way, they are receiving the right care from their family doctor with support from our clinic, instead of needing to visit the emergency department for care."

When one of their patients does require emergency care, Loretta follows-up with them to ensure the right supports are in place to help them get better. They are then seen in the clinic for testing and a review of their management plan to prevent the need for additional hospital visits.

"The best part of my job is seeing the difference we can make in quality of life for our patients," said Loretta. "We had one patient who was able to quit smoking and become physically active. He now spends his time walking and playing at the park with his grandchildren – something he only dreamed about before."

Improving Access to, and Coordination of, Addictions and Mental Health Services

While improving access to addictions and mental health services is a provincial priority, through data collection and community engagement as part of the IHSP it was also identified as a local priority. Some of the issues of concern locally are: increasing prevalence of both mood and anxiety disorders, higher rates of substance use among Waterloo Wellington students, a high rate of intentional self harm, and our local Aboriginal community has reported a lack of mental health services, especially for youth.

Goal: to reduce substance use among youth to the provincial average in all categories, reduce mental health issues among youth, decrease readmissions and inappropriate ED use to provincial averages and improve access to services.

Successes:

- ✓ Opened 48 addictions supportive housing units to increase social and health outcomes for individuals with substance use issues.
- ✓ The Self Help Alliance and the Canadian Mental Health Association are implementing a best practice suicide intervention program for people who have had multiple suicide attempts and who are experiencing suicidal thoughts.
- ✓ Cambridge Memorial Hospital will be opening an interim 22 bed Schedule 1 mental health inpatient unit.

Improving Chronic Disease Prevention and Management

Prevalence rates for diabetes and hypertension have increased between 2003 and 2009 both at the provincial level and locally in Waterloo Wellington. Of particular concern is the amount that these rates have increased between 2003 and 2009 in the WWLHIN (83% for diabetes and 20% for hypertension) compared to the province (40% for diabetes and 17% for hypertension).

Disparities in disease rates among cultural groups also need to be addressed. For example, rates of diabetes, asthma, hypertension and arthritis are higher for Aboriginal residents in WWLHIN compared to the total WWLHIN population; in some cases, the rates are almost twice as high.

Goal: To improve the provision of chronic disease management and self care and improve access to specialized services for patients with chronic conditions.

Successes:

- ✓ Established a Regional Diabetes Coordination Centre (RCC) and related programs.
- ✓ Implemented a comprehensive bariatric program.
- ✓ Implemented a new central intake process for diabetes education referrals utilizing a common referral form. This process improved navigation of the system and access to services.
- ✓ Through funding from Ontario Renal Network the Regional Program has been able to hire a Vascular Access Coordinator and an Independent Dialysis. Navigator with the goal of improving the rates in these two areas.
- ✓ Expanded peritoneal dialysis to long term care homes.
- ✓ Expanded smoking cessation initiatives across the WWLHIN.

Supportive Housing Provides Foundation for Better Health

For Mike*, holding down a job was extremely difficult. Struggling with an addiction to alcohol and related health issues prevented him from working, which resulted in him being frequently homeless. Unable to focus on surviving and recovering at the same time left him in a hopeless cycle of crisis treatment and relapse.

"Not only does this provide a poor quality of life for the individual but it is taxing on our health system. These individuals require greater support and stability to make the lasting changes needed to get better and stay better," said Heather Kerr, Executive Director, Stonehenge Therapeutic Community. "That's why our new addiction supportive housing program is so needed and so important."

With funding from the Waterloo Wellington Local Health Integration Network, and through a partnership with Waterloo Regional Homes for Mental Health, House of Friendship, and the Canadian Mental Health Association Grand River Branch, local residents now have access to permanent and transitional Addiction Supportive Housing units.

Twenty-nine units are currently open -- four in Cambridge, 12 in Guelph, 12 in Kitchener-Waterloo, and one in a rural community. An additional three units will open in rural Wellington County when matched with clients in need.

For Mike, access to safe housing was life-changing. He completed Stonehenge's long-term treatment program and then had the opportunity to move into the transitional addiction supportive housing. There, he found a safe place with others he could relate to. He was able to focus on his recovery and gained a number of life skills that would support him in the future.

**Name changed to protect client's privacy.*

Decreasing Alternate Level of Care (ALC) Days

ALC patients are those waiting in hospital for care in a more appropriate place such as home with supports, long-term care, palliative care, rehabilitation, mental health care, and more. Approximately 100 hospital beds in Waterloo Wellington are occupied by ALC patients on any given day. While seniors account for 50% of all acute care hospital days, they often face the most challenge when trying to get home again and account for 87% of all ALC days.

When beds are designated as ALC, they reduce available capacity for new patients arriving through the emergency department or waiting for surgeries, thus putting further pressure on wait times. As a result of local initiatives, ALC days in hospitals were reduced from 27% in November 2008 to 17.65% in April 2011 meaning that same percentage of people were receiving the right care in community rather than inappropriately waiting in hospital.

Goal: to improve acute care bed utilization and improve access to community services to enhance hospital discharge opportunities.

Successes:

- ✓ Made targeted investments aimed at preventing people from unnecessarily becoming ALC: Hospital Elder Life Program (H.E.L.P) – a program which provides care to the frail elderly to help avoid serious complications of hospitalization; and Longer- Term Ventilator Weaning.
- ✓ Identified opportunities for LTC homes to accept higher acuity level residents.
- ✓ Launched 12 transitional living beds for Acquired Brain Injury
- ✓ Expanded the Integrated Assisted Living Program pilot for seniors
- ✓ Launched a 33 bed supportive housing program
- ✓ Opened 298 long-term care beds – including 96 at St. Joseph's Health Centre in Guelph and 96 at the Village of Riverside Glen. Another 96 beds are currently under construction at Hilltop manor in Cambridge.
- ✓ Implemented the Home First Philosophy which helps more patients go home from hospital safely where they can make informed decisions about their future care arrangements. A re-launch of the philosophy in 2011 has had a great impact on reducing ALC days across the WWLHIN.

Celebrating Low Number of Patients Waiting in Hospital for Long-Term Care

In early 2012, the Waterloo Wellington LHIN celebrated a huge success – having the lowest number of patients, designated "Alternate Level of Care" (ALC), waiting in hospital for long-term care in the province*. This means that more residents in Waterloo Wellington are receiving the right care, in the right place, at the right time.

Local hospitals, in partnership with the Waterloo Wellington Community Care Access Centre (WWCCAC) and WWLHIN, have implemented the 'Home First' philosophy which makes going home from hospital, where most patients want to go, the first option. Once there they can make informed choices about their future living arrangements. This helps patients to receive quality care in the most appropriate place, while reducing ALC days in hospitals.

St. Mary's General Hospital has seen particular success since it completed a Home First Refresh in August 2011. "In the beginning of 2011, it was not uncommon for us to have 20-30 people waiting in our hospital for a long-term care bed," said Jayne Menard, Director of Medicine & Surgery for St. Mary's. "Now we often have just two or three patients waiting for long-term care, and some days none at all."

St. Mary's attributes its success to strong relationships with staff and community partners, and a change in how staff talk to patients and families about going home. "Home First starts on admission," said Jayne. "We say, when you are medically stable, you will go home. It's the best place for you to be. In the mean time, we are going to help you get better and make sure that when you go home, you have all of the supports in place for you to continue getting better."

**Data provided by the Ontario Hospital Association as of January 12, 2012.*

Providing Education Opportunities for Local Health Service Providers

As part of the WWLHIN's commitment to providing high-quality learning opportunities for local health service providers, we continuously seek input from participants at our engagement events. Over the last few years, through event evaluation surveys, local care providers told us that in addition to the annual Champions of Change Symposium, they would benefit from smaller, hands on learning opportunities.

In response to this feedback, we developed Change Labs - hands-on, collaborative, workshops where local health care providers can learn about new opportunities and tools available in the local health system.

The goal of Change Lab is to inspire the people of the local health system to become the Champions of Change we celebrate at our annual symposium.

This year we hosted two Change Lab workshops.

In March, the WWLHIN brought together leaders from across the health system to participate in one of two half-day sessions on the LEADS in a Caring Environment Framework. This leadership framework defines the knowledge, skills, and attitudes a leader needs to exhibit in order to successfully contribute to an effective and efficient local health system.

In April, in partnership with the Waterloo Wellington Rural Health Network, We brought together partners in health, education, justice, community and other sectors to collectively challenge participant's understanding of how poverty affects health.

Community

Community Engagement

Since their inception in 2005, LHINs have been working closely with residents and local health service providers to identify and plan for local health needs.

Waterloo Wellington residents and health service providers have been engaged in a variety of ways. They have helped to identify local needs and challenges, suggested solutions, and developed the priorities for our local health system.

Community engagement continues to be an essential ingredient in the work of the WWLHIN. Community engagement activities through 2011 – 2012 focused on the WWLHIN Rehab Review, the development of a local French Language Planning Entity, and targeted engagements with local physicians.

WWLHIN Primary Care Physician Engagement

In alignment with Ontario's Action Plan for Health Care – which highlights the important role that primary care providers have in the local health system – the WWLHIN began a focused engagement strategy with primary care providers this past fiscal year.

In October we partnered with the Waterloo Wellington Community Care Access Centre and the Ontario Medical Association to co-host two education sessions with local physicians. The purpose of these sessions was to ensure that local physicians had access to up-to-date information on key health system initiatives that would help them improve access to care for their patients.

These sessions included information on the Home First philosophy, updates on new clinical tools available locally including ClinicalConnect, and also provided physicians with an opportunity to share their successes and ideas for improvements in the local health system.

Ongoing Engagement Activities

The WWLHIN has actively encouraged and planned community engagement activities as part of our annual planning process. Meaningful community engagement supports the WWLHIN's goals to inform, educate, consult, involve and empower stakeholders in health service planning and decision-making processes. Supporting our diverse communities is achieved through a number of engagement strategies.

A 15-member Community Council meets regularly to provide valuable input to the board. This is a group of individuals who bring their community knowledge, experience and interest in local health care to the WWLHIN, and in turn, back to the community.

Presentation opportunities to community-based organizations are actively solicited. The WWLHIN also participated at local events such as the Seniors Wellness Fair, Hike for Hospice, Passport Day, and more. These venues are excellent networking opportunities for the WWLHIN with general consumers, community partners and health service providers.

The WWLHIN was host to the 10th Champions of Change symposiums over the past fiscal year. Champions of Change symposiums are held to offer health service providers and

community members an opportunity to come together to share experiences that lead to quality and process improvements in care for local residents.

More than 230 participants attended the spring 2011 event, making it the largest Champions of Change event to date. Learning sessions throughout the day focused on addressing the determinants of health and how population health inequities are impacting the sustainability of our health system. We also continued to receive input on community needs from our health service providers and various committees on a daily basis.

French Language Community Engagement and Health Services

The Waterloo Wellington (WW) and Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Networks (LHINs) partnered leading to the signing of an unprecedented funding and accountability agreement with the *Entité de planification pour les services en français dans les régions de Waterloo, Wellington, Hamilton, Niagara*. The entity is a French language health planning entity shared by the two LHINs.

Over the last year, the Waterloo Wellington LHIN has been working in partnership with the French Planning Entity to develop a Joint Action Plan and a work plan to increase access to health services for the francophone community. According to the Community Profile developed by the Entité de planification pour les services en français (French Language Planning Entity), there are more than 15,300 French speaking residents in the Waterloo Wellington LHIN and a large part of the increasing population is due to the arrival of new immigrants coming from African countries who while sharing a language, have completely different cultures.

The WWLHIN continues to be involved with the various francophone groups in the area, including the seven French schools and the two French school boards serving the area. In addition, the WWLHIN supported the Public Health offices in Waterloo Region and Wellington County in a consultation process with the francophone community to plan the new 'Healthy Communities' program in the area.

While the WWLHIN has no French language designated communities, it is important to take into consideration the needs of the francophone community to ensure the well being of all residents in the area. The French-language mental health telemedicine program at Trellis Mental Health and Developmental Services has been implemented and has become a model of Best Practice to improve access to health care for the francophone population.

On January 1st, 2012, the Waterloo Wellington Community Care Access Centre became a designated French language service provider and the WWLHIN has been supporting them in the development of an implementation plan that will respond to the needs of the francophone community while taking into consideration the limited availability of French-speaking professional resources.

Aboriginal Planning Activities and Health Services

The local Aboriginal community in Waterloo Wellington is 100 per cent urban based. There are no reserve lands or Indian Friendship Centres within our boundaries. Aboriginal residents in need of health care access services from the local mainstream health system or travel to service providers outside of the WWLHIN to access culturally appropriate care.

In 2010, the WWLHIN began an extensive engagement project to learn about the specific health needs of the Aboriginal community in Waterloo Wellington.

Over the past year we have been working with local Aboriginal partners to build relationships, and bring individuals and organizations together to look at ways to address the recommendations in the Health Needs Assessment.

In addition to this work, we have also been providing presentations to local health service providers on the health status and health needs of local Aboriginal residents. The Aboriginal Health Needs Assessment is available on our website at www.wwlhin.on.ca in the "Engaging our Communities" section.

Integrity

WWLHIN Operations

Total revenue for 2011-12 includes funding for WWLHIN operations and initiatives, and funding for health service providers in accordance with public sector reporting guidelines.

In 2011-2012, the WWLHIN operational and initiatives budget was $5.5 million. In total, approximately half of one per cent, (0.56%), of our total funding is used for WWLHIN operations to support the important role of planning, coordinating and integrating for the local health system.

The WWLHIN ended the fiscal year with an operational surplus of $103,139. The WWLHIN had a staff complement of 31 full time equivalent (FTE) positions focused on improving quality outcomes, access to care and value for taxpayer dollars. Our full and contracted staff have diverse skill sets and backgrounds and include nurses, allied health professionals and former executives from large health service providers, government and private sector organizations, our Primary Care Physician Lead, Emergency Department Physician Lead and Geriatric Services Lead.

Giving Back to our Community

Throughout 2010 - 2011, the WWLHIN focused on fun team building activities that also provided great benefit to the community. A group of WWLHIN staff and their families spent time helping to plant seedlings that will become trees along rural roads to support safety. Multiple food drives were held to support local food banks and a bake sale was held to support the Federated Health Campaign which supports provincial health organizations.

Looking to the Future

Moving forward, our Mission is to lead a high-quality, integrated health system for our residents.

Through the new vision of "Better Health – Better Futures" and driven by the core value of "acting in the best interest of our residents' health and well-being", the WWLHIN will shift its focus to four Strategic Priorities: Enhancing Access to Primary Care, Enhancing Coordination and Transitions of Care for Targeted Populations, Implementing Evidence Based Practice to Drive Quality and Holding the Gains on progress we have made to date in areas such as wait times for CT, MRI, cardiac care, cataract and cancer surgery.

These local priorities are aligned with Ontario's Action Plan for Health Care and focus on the local health needs of Waterloo Wellington residents. Local health service providers are aligning their strategic plans with that established by the Network to enable the development of a truly integrated system. Through this focused and aligned direction, we are going to achieve better health, better care, and better value for our residents.

Financial statements of

Waterloo Wellington Local Health Integration Network

March 31, 2012

Deloitte

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Independent Auditor's Report

To the Members of the Board of Directors of the
Waterloo Wellington Local Health Integration Network

We have audited the accompanying financial statements of Waterloo Wellington Local Health Integration Network, which comprise the statement of financial position as at March 31, 2012, and the statements of financial activities, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Waterloo Wellington Local Health Integration network as at March 31, 2012 and the results of its financial activities, changes in its net debt and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
June 7, 2012

Waterloo Wellington Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	**561,984**	1,042,057
Other receivables	**248,340**	49,732
	810,324	1,091,789
Liabilities		
Accounts payable and accrued liabilities	**734,616**	1,076,709
Due to Ministry of Health and Long-Term Care (Note 3b)	**101,479**	33,086
Due to eHealth Ontario (Note 3c)	**1,660**	-
Due to the Local Health Integration Networks Shared Services Office (Note 4)	**-**	8,934
Deferred capital contributions (Note 5)	**288,192**	290,752
	1,125,947	1,409,481
Commitments (Note 6)		
Net debt	**(315,623)**	(317,692)
Non-financial assets		
Prepaid expenses	**27,431**	26,940
Capital assets (Note 7)	**288,192**	290,752
Accumulated surplus	**-**	-

Approved by the Board

Board Chair

Finance and Audit Committee Chair

Waterloo Wellington Local Health Integration Network

Statement of financial activities
year ended March 31, 2012

	Budget (Unaudited) (Note 8)	2012 Actual	2011 Actual
	$	$	$
Revenue			
Ministry of Health and Long-Term Care funding			
Health Service Providers transfer payments (Note 9)	904,863,389	979,769,095	920,425,127
Local Health Integration Network operations - general and administrative	4,419,719	4,344,784	4,478,487
eHealth (Note 10a)	-	600,000	600,000
Emergency Department Lead (Note 10b)	-	75,000	75,000
Emergency Department/Alternative Levels of Care Lead (Note 10c)	-	100,000	100,000
Aboriginal Planning (Note 10d)	-	5,000	5,000
French Language Services (Note 10e)	-	106,000	50,537
Health Equity Impact Assessment (Note 10f)	-	-	-
Critical Care Lead (Note 10g)	-	75,000	75,000
Primary Care Lead (Note 10h)	-	21,875	-
Behavioural Supports Ontario (Note 10i)	-	57,000	-
Amortization of deferred capital contributions (Note 5)	-	77,495	105,306
	909,283,108	985,231,249	925,914,457
Funding repayable to Ministry of Health and Long-Term Care (Note 3b)	-	(101,479)	(31,608)
Funding repayable to eHealth Ontario (Note 3c)	-	(1,660)	-
	909,283,108	985,128,110	925,882,849
Expenses			
Transfer payments to Health Service Providers (Note 9)	904,863,389	979,769,095	920,425,127
Local Health Integration Network operations - general and administrative (Note 11)	4,419,719	4,344,398	4,554,707
eHealth (Note 10a)	-	598,340	600,000
Emergency Department Lead (Note 10b)	-	73,710	75,000
Emergency Department/Alternative Levels of Care Lead (Note 10c)	-	100,000	100,000
Aboriginal Planning (Note 10d)	-	5,000	5,000
French Language Services (Note 10e)	-	106,000	46,537
Health Equity Impact Assessment (Note 10f)	-	-	1,478
Critical Care Lead (Note 10g)	-	56,153	75,000
Primary Care Lead (Note 10h)	-	18,414	-
Behavioural Supports Ontario (Note 10i)	-	57,000	-
	909,283,108	985,128,110	925,882,849
Annual surplus and closing accumulated surplus	-	-	-

Waterloo Wellington Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	Budget (Unaudited) (Note 8)	2012	2011
		$	$
Annual surplus	-	-	-
Change in prepaid expenses	-	(491)	(26,940)
Acquisition of capital assets	-	(74,935)	(11,903)
Amortization of capital assets	-	77,495	105,306
Decrease in net debt	-	2,069	66,463
Opening net debt	-	(317,692)	(384,155)
Closing net debt	-	(315,623)	(317,692)

Waterloo Wellington Local Health Integration Network

Statement of cash flows
year ended March 31, 2012

	2012	2011
	$	$
Operating activities		
Annual surplus	-	-
Less: items not affecting cash		
Amortization of capital assets	**77,495**	105,306
Amortization of deferred capital contributions (Note 5)	**(77,495)**	(105,306)
	-	-
Changes in non-cash operating items		
Decrease in due from Ministry of Health and Long-Term Care	-	43,500
Decrease in due from Local Health Integration Networks Shared Services Office	-	1,233
(Increase) in other receivables	**(198,608)**	(49,732)
(Decrease) increase in accounts payable and accrued liabilities	**(342,093)**	49,324
Increase in due to Ministry of Health and Long-Term Care	**68,393**	5,800
Increase in due to eHealth Ontario	**1,660**	-
(Decrease) increase in due to Local Health Integration Networks Shared Services Office	**(8,934)**	8,934
(Decrease) in deferred revenue	-	(46,537)
(Increase) in prepaid expenses	**(491)**	(26,940)
	(480,073)	(14,418)
Acquisition of capital assets	**(74,935)**	(11,903)
Financing activity		
Capital contributions received (Note 5)	**74,935**	11,903
Net (decrease) in cash	**(480,073)**	(14,418)
Cash, beginning of year	**1,042,057**	1,056,475
Cash, end of year	**561,984**	1,042,057

Waterloo Wellington Local Health Integration Network

Notes to the financial statements
March 31, 2012

1. Description of business

The Waterloo Wellington Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Waterloo Wellington Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers all of the County of Wellington, the Region of Waterloo, and the City of Guelph. The LHIN also contains part of Grey County, which is split with the South West and the North Simcoe Muskoka LHINs. The LHIN enters into service accountability agreements with health service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to Health Service Providers ("HSPs"), effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSPs Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

Commencing April 1, 2007, all funding payments to LHIN managed HSPs in a LHIN geographic area, have flowed through each LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in each LHIN's financial statements for the year ended March 31, 2012.

The LHIN statements do not include any Ministry managed programs

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario-LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable. Through the accrual basis of accounting, expenses include non-cash items such as the amortization of capital assets and impairments in the value of assets.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of financial activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment, furniture and fixtures	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

2. Significant accounting policies (continued)

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of financial activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC and eHealth Ontario

In accordance with the MLPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the eHealth Ontario.

a) The amount repayable to the MOHLTC and eHealth Ontario related to current year activities is made up of the following components:

	Funding received	Eligible expenses	2012 Excess funding	2011 Excess funding
	$	$	$	$
Transfer payments to HSPs	979,769,095	979,769,095	-	-
LHIN operations	4,422,279	4,344,398	77,881	29,086
eHealth	600,000	598,340	1,660	-
Critical Care Lead	75,000	56,153	18,847	-
Emergency Department Lead	75,000	73,710	1,290	-
Emergency Department/Alternative Levels of Care Lead	100,000	100,000	-	-
Aboriginal Planning	5,000	5,000	-	-
Ontario Diabetes Strategy	-	-	-	-
French Language Services	106,000	106,000	-	4,000
Diabetes Self-Management	-	-	-	-
Health Equity Pilot	-	-	-	(1,478)
Primary Care Lead	21,875	18,414	3,461	-
Behavioural Supports Onatrio	57,000	57,000	-	-
	985,231,249	985,128,110	103,139	31,608

3. Funding repayable to the MOHLTC and eHealth Ontario (continued)

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2012	2011
	$	$
Due to MOHLTC, beginning of year	33,086	27,286
Paid to MOHLTC during year	(33,086)	(25,808)
Funding repayable to the MOHLTC related to current year activities (Note 3a)	101,479	31,608
Due to MOHLTC, end of year	101,479	33,086

c) The amount due to the eHealth Ontario at March 31 is made up as follows:

	2012	2011
	$	$
Due to eHealth Ontario, beginning of year	-	-
Paid to eHealth Ontario during year	-	-
Funding repayable to the eHealth Ontario related to current year activities (Note 3a)	1,660	-
Due to eHealth Ontario, end of year	1,660	-

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all the LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end are recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHINC was formed in fiscal 2011 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in:

- fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system;
- their role as system manager;
- where appropriate, the consistent implementation of provincial strategy and initiatives;
- the identification and dissemination of best practices.

LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the MOHLTC.

5. Deferred capital contributions

	2012	2011
	$	$
Balance, beginning of year	**290,752**	384,155
Capital contributions received during the year	**74,935**	11,903
amortization for the year	**(77,495)**	(105,306)
	288,192	290,752

6. Commitments

The LHIN has commitments under various operating leases and maintenance contracts related to building, software and equipment. Lease renewals are likely. Minimum lease payments due in each of the next five years are as follows:

	$
2013	344,459
2014	348,558
2015	352,762
2016	370,137
2017	346,740
Thereafter	1,062,823

The LHIN also has funding commitments to HSPs associated with accountability agreements. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Capital assets

			2012	2011
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office equipment, furniture and fixtures	**338,622**	**206,103**	**132,519**	182,348
Computer equipment	**48,756**	**38,748**	**10,008**	20,016
Web development	**23,043**	**23,043**	**-**	-
Leasehold improvements	**764,184**	**618,519**	**145,665**	88,387
	1,174,605	**886,413**	**288,192**	290,751

8. Budget figures

The budget figures reported in the Statement of financial activities reflect the initial budget at April 1, 2011 as approved by the LHIN Board. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $979,769,095 is derived as follows:

	$
Initial budget	**904,863,389**
Additional funding received during the year	**74,905,706**
Final budget	**979,769,095**

The final LHIN general and administrative and specific initiatives budget of $4,344,784 is derived as follows:

	$
Initial budget	**4,419,719**
Additional funding received during the year	**-**
Amount treated as capital contributions made during the year	**(74,935)**
Final budget	**4,344,784**

No budget was set for items appearing on the Statement of changes in net debt.

9. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $979,769,095 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in fiscal 2012 as follows:

	2012	2011
	$	$
Operations of hospitals	**594,171,803**	562,147,855
Grants to compensate for municipal taxation - public hospitals	**159,225**	159,225
Long term care homes	**164,685,974**	147,875,383
Community care access centre	**109,085,432**	101,024,036
Community support services	**17,937,579**	16,998,689
Assisted living services in supportive housing	**5,882,562**	6,241,198
Community health centres	**16,998,621**	16,579,197
Community mental health programs	**31,014,019**	28,419,993
Specialty psychiatric hospitals	**30,633,800**	30,209,100
Addictions programs	**9,200,080**	8,803,304
Health infrastructure renewal fund	**-**	1,967,147
	979,769,095	920,425,127

10. Separate funding amounts were received by the LHIN from the MOHLTC and eHealth Ontario for specific initiatives

a) eHealth

The LHIN received funding of $600,000 (2011 - $600,000) from eHealth Ontario. These funds were used toward initiatives in support of its strategic eHealth Plan as defined in its Integrated Health Services Plan. eHealth expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries, benefits and consulting services	506,220	506,893
Other	92,120	93,107
	598,340	600,000

b) Emergency Department Lead

The LHIN received funding of $75,000 (2011 - $75,000) related to the Emergency Department Lead. Emergency Department Lead expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries, benefits and consulting services	72,000	74,030
Other	1,710	970
	73,710	75,000

c) Emergency Department/Alternative Levels of Care Lead

The LHIN received funding of $100,000 (2011 - $100,000) related to the Emergency Department/Alternative Levels of Care Lead. Emergency Department/Alternative Levels of Care Lead expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries, benefits and consulting services	100,000	100,000

d) Aboriginal Planning

The LHIN received funding of $5,000 (2011 - $5,000) related to Aboriginal Planning. Aboriginal Planning expenses incurred during the year are as follows:

	2012	2011
	$	$
Community engagement	5,000	5,000

10. Separate funding amounts were received by the LHIN from the MOHLTC and eHealth Ontario for specific initiatives (continued)

e) French Language Services

The LHIN received funding of $106,000 (2011 - $50,537) related to French Language Services. French Language Services expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries, benefits and consulting services	76,304	17,610
Other	29,696	28,927
	106,000	46,537

f) Health Equity Impact Assessment

The LHIN received funding of $nil (2011 - $ nil) related to Health Equity Impact Assessment. No Health Equity Impact Assessment expenses were incurred during the year.

	2012	2011
	$	$
Other	-	1,478

g) Critical Care Lead

The LHIN received funding of $75,000 (2011 - $75,000) related to Critical Care Lead. Critical Care Lead expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries, benefits and consulting services	54,000	75,000
Other	2,153	-
	56,153	75,000

h) Primary Care Lead

The LHIN received funding of $21,875 (2011 - $ nil) related to the Primary Care Lead. Primary Care Lead expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries, benefits and consulting services	18,000	-
Other	414	-
	18,414	-

10. Separate funding amounts were received by the LHIN from the MOHLTC and eHealth Ontario for specific initiatives (continued)

i) Behavioural Supports Ontario

The LHIN received funding of $57,000 (2011 - $ nil) related to the Behavioural Supports Ontario. Behavourial Supports Ontario expenses incurred during the year are as follows:

	2012	2011
	$	$
Salaries, benefits and consulting services	57,000	-

11. LHIN operations - general and administrative expenses

The Statement of financial activities presents expenses by function. The following classifies general and administrative expenses by object:

	2012	2011
	$	$
Salaries and benefits	2,761,302	2,949,762
Occupancy	295,412	317,182
Amortization	77,494	105,306
Shared Services	465,989	379,155
LHIN Collaborative	26,971	45,000
Public relations	53,964	64,715
Consulting services	232,828	107,370
Supplies	85,433	81,998
Board Chair per diems	68,450	80,805
All other board members' per diems	47,700	35,100
Other governance costs	34,700	45,674
Mail, courier and telecommunications	64,657	62,038
Other	129,498	280,603
	4,344,398	4,554,708

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 30 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2012 was $267,312 (2011 - $281,497) for current service costs and is included as an expense in the Statement of financial Activities. The last actuarial valuation was completed for the plan on December 31, 2011. At that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provision of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

14. Comparative figures

Certain comparative figures have been reclassified to conform to the current year presentation.

Waterloo Wellington **LHIN**

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